



MRI SCREENING FORM

Name: _____ DOB: ____/____/____
Height: _____ Weight: _____ Sex: ____ Male ____ Female

Please circle any that apply

Do you presently have any of the following :

Pacemaker
Aneurysm Clips
Body Jewelry
Bypass Surgery
Cardiac Defibrillator
Chemotherapy Pump
Hearing Implant
Heart Valve
Insulin Pump
IUD
Joint Replacement
Mesh Implants
Metal Fragments in Eyes
Metal Rods, Plates, Pins, Screws, Nails or Clips
Neurostimulator
Prosthesis
Shrapnel of Bullets
Shunt
Wire Suture

Signature: _____ **Date:** ____/____/____

Pregnancy Consent

Although there are no known risks, Magnetic Resonance Imaging is performed after the first trimester of pregnancy only under special circumstances.